LifeWise
Health Plan of Washington

Highlights of your Health Care Coverage

Effective Date: 01/01/2027

Any deductibles, copays, and coinsurance percentages shown are amounts for which you're responsible.
Medical Benefits apply after the calendar-year deductible is met unless otherwise noted, or if the cost share is a copay.

MEDICAL PLAN	CASCADE SELECT VITAL GOLD	
	LIFEWISE ALPINE IN-NETWORK	OUT-OF-NETWORK
Deductible (In-network only - Family embedded deductible 2X Individual)	$2,200	Not Covered
Coinsurance	20%	Not Covered
Out of Pocket Maximum (includes deductible, copays, coinsurance and pharmacy) (Family embedded OOP max 2X Individual)	$11,000	Not Covered
Designated PCP Office Visit Cost Share	$15 Copay, applies to the $11,000 Out of Pocket Maximum	Not Covered
Specialist and non designated PCP Office Visit Cost Share	$40 Copay, applies to the $11,000 Out of Pocket Maximum	Not Covered
Annual Maximum	Unlimited	Not Covered
1 Ambulatory Patient Services		
Professional Office Visit	Designated PCP: $15 Copay, applies to the $11,000 Out of Pocket Maximum; Specialist and non designated PCP: $40 Copay, applies to the $11,000 Out of Pocket Maximum	Not Covered
Telemedicine by Traditional Provider – General Medical	Designated PCP: $15 Copay, applies to the $11,000 Out of Pocket Maximum; Specialist and non designated PCP: $40 Copay, applies to the $11,000 Out of Pocket Maximum	Not Covered
Urgent Care Office Visits	$35 Copay, applies to the $11,000 Out of Pocket Maximum	Not Covered

MEDICAL PLAN	CASCADE SELECT VITAL GOLD	
	LIFEWISE ALPINE IN-NETWORK	OUT-OF-NETWORK
Outpatient Professional Services	$2,200 Deductible, then 20% Coinsurance, applies to the $11,000 Out of Pocket Maximum	Not Covered
Contraceptive Management Services (Unlimited)	Covered in Full	Not Covered
2 Emergency and Transportation Services		
Emergency Room - Facility	$2,200 Deductible, then $800 Copay, applies to the $11,000 Out of Pocket Maximum	$2,200 Deductible, then $800 Copay, applies to the $11,000 Out of Pocket Maximum
Ambulance Service - Ground (Unlimited)	$375 Copay, applies to the $11,000 Out of Pocket Maximum	$375 Copay, applies to the $11,000 Out of Pocket Maximum
Ambulance Service - Air (Unlimited)	$375 Copay, applies to the $11,000 Out of Pocket Maximum	$375 Copay, applies to the $11,000 Out of Pocket Maximum
3 Hospitalization		
Inpatient Medical and Surgical Room and Board (Unlimited)	$2,200 Deductible, then $650 Copay per Day up to 5 Days per Admit, applies to the $11,000 Out of Pocket Maximum	Not Covered
Inpatient Professional Services	$2,200 Deductible, then 0% Coinsurance, applies to the $11,000 Out of Pocket Maximum	Not Covered
Skilled Nursing Facility (60 days PCY; includes room and board, and facility billed professional and ancillary fees)	$2,200 Deductible, then $350 Copay per Day, applies to the $11,000 Out of Pocket Maximum	Not Covered
Hospice Inpatient Facility (Unlimited)	$2,200 Deductible, then $650 Copay per Day up to 5 Days per Admit, applies to the $11,000 Out of Pocket Maximum	Not Covered
Organ Transplants (Unlimited)	Covered as any other service	Not Covered
4 Maternity & Newborn Care		
Maternity Delivery - Inpatient Facility (Coverage for subscriber, spouse, dependent)	$2,200 Deductible, then $650 Copay per Day up to 5 Days per Admit, applies to the $11,000 Out of Pocket Maximum	Not Covered
Maternity Prenatal, Delivery and Postnatal Care - Professional Services (Coverage for subscriber, spouse, dependent)	Covered in Full	Not Covered
Fertility Treatment & Assisted Reproduction Procedures (Artificial insemination in vivo covered; other assisted reproduction treatments excluded)	$2,200 Deductible, then 20% Coinsurance, applies to $11,000 Out of Pocket Maximum	Not covered
5 Mental Health & Substance Use Disorder Services, including Behavioral Health Treatment		

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Chemical Dependency Office Visit (Unlimited)	$15 Copay, applies to the $11,000 Out of Pocket Maximum	Not Covered
Chemical Dependency Outpatient Facility (Unlimited)	$15 Copay, applies to the $11,000 Out of Pocket Maximum	Not Covered
Chemical Dependency Inpatient Facility (Unlimited)	$2,200 Deductible, then $650 Copay per Day up to 5 Days per Admit, applies to the $11,000 Out of Pocket Maximum	Not Covered
Mental Health Office Visit (Unlimited)	$15 Copay, applies to the $11,000 Out of Pocket Maximum	Not Covered
Mental Health Outpatient Facility (Unlimited)	$15 Copay, applies to the $11,000 Out of Pocket Maximum	Not Covered
Mental Health Inpatient Facility (Unlimited)	$2,200 Deductible, then $650 Copay per Day up to 5 Days per Admit, applies to the $11,000 Out of Pocket Maximum	Not Covered
6 Prescription Drug		
Formulary Drug List	M4 Tier 1 = Preferred Generic Tier 2 = Preferred Brand Tier 3 = Non-preferred Generic and Brand Tier 4 = Specialty	Not Covered
Prescription Drugs - Retail (Retail: 90 Days, if applicable one copay every 30 day supply; Mail: 90 Days; Specialty: 30 Days)	Tier 1 = $10 Tier 2 = $75 Tier 3 = Subject to Deductible, then 20% Tier 4 = Subject to Deductible, then 20% (cost shares apply to the OOP Max)	Not Covered
Prescription Drugs - Mail (Retail: 90 Days, if applicable one copay every 30 day supply; Mail: 90 Days; Specialty: 30 Days)	Tier 1 = $30 Tier 2 = $225 Tier 3 = Subject to Deductible then 20% Tier 4 = Subject to Deductible, then 20% (cost shares apply to the OOP Max)	Not Covered
7 Rehabilitative & Habilitative Services & Devices		
Inpatient Rehabilitation (30 days PCY)	$2,200 Deductible, then $650 Copay per Day up to 5 Days per Admit, applies to the $11,000 Out of Pocket Maximum	Not Covered
Outpatient Rehabilitation - Physical, Occupational Therapy (25 visits PCY)	$30 Copay, applies to the $11,000 Out of Pocket Maximum	Not Covered
Outpatient Habilitation - Physical, Occupational Therapy (25 visits PCY)	$30 Copay, applies to the $11,000 Out of Pocket Maximum	Not Covered
Outpatient Massage Therapy (Applies to the outpatient rehab limit)	$30 Copay, applies to the $11,000 Out of Pocket Maximum	Not Covered
Outpatient Speech Therapy (Applies to the outpatient rehab limit)	$30 Copay, applies to the $11,000 Out of Pocket Maximum	Not Covered

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Inpatient Habilitation (30 days PCY)	$2,200 Deductible, then $650 Copay per Day up to 5 Days per Admit, applies to the $11,000 Out of Pocket Maximum	Not Covered
Durable Medical Equipment (Unlimited)	$2,200 Deductible, then 20% Coinsurance, applies to $11,000 Out of Pocket Maximum	Not Covered
8 Laboratory/Imaging Services		
Diagnostic Laboratory & Pathology	$30 Copay, applies to the $11,000 Out of Pocket Maximum	Not Covered
Diagnostic Imaging - Basic	$30 Copay, applies to the $11,000 Out of Pocket Maximum	Not Covered
Diagnostic Imaging - Major (MRI, CT, PET)	$2,200 Deductible, then $300 Copay, applies to the $11,000 Out of Pocket Maximum	Not Covered
9 Preventive/Wellness Services		
Preventive Office Visit (Unlimited, subject to standard medical guidelines)	Covered in Full	Not Covered
Immunizations (Unlimited, subject to standard medical guidelines)	Covered in Full	Not Covered
Preventive Laboratory Screens	Covered in Full	Not Covered
Preventive Imaging	Covered in Full	Not Covered
Breast Cancer Screening (including mammography)	Covered in Full	Not Covered
10 Pediatric Services, including Oral & Vision Care		
Pediatric Vision Exam (1 PCY Under age 19)	Covered in Full	Covered in Full
Pediatric Eyewear (Under age 19: One pair of glasses PCY (frames & lenses). 12 month supply of contacts PCY, in lieu of glasses (frames & lenses).)	Covered in Full	Covered in Full
Pediatric Dental - Major	Not Covered	Not Covered
Virtual Care Services		
Telemedicine – General Medical (Virtual Care Only)	Designated PCP: $15 Copay, applies to the $11,000 Out of Pocket Maximum; Specialist and non designated PCP: $40 Copay, applies to the $11,000 Out of Pocket Maximum	Not Covered
Telemedicine - Mental Health (Virtual Care Only)	Subject to Mental Health Office Visit Cost Share	Not Covered
Telemedicine - Chemical Dependency (Virtual Care Only)	Subject to Chemical Dependency Outpatient Office Visit Cost Share	Not Covered
Routine Hearing		
Routine Hearing Exam (1 PCY)	$15 Copay, applies to the $11,000 Out of Pocket Maximum	$15 Copay, applies to the $11,000 Out of Pocket Maximum
Routine Hearing Aids and Hardware (1 device per ear every 3 years)	Waive Deductible, then 20% Coinsurance, applies to $11,000 Out of Pocket Maximum	Waive Deductible, then 20% Coinsurance, applies to $11,000 Out of Pocket Maximum

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Alternative Care		
Chiropractic (10 visits PCY)	$15 Copay, applies to the $11,000 Out of Pocket Maximum	Not Covered
Acupuncture (Unlimited)	$15 Copay, applies to the $11,000 Out of Pocket Maximum	Not Covered
Naturopath	Designated PCP: $15 Copay, applies to the $11,000 Out of Pocket Maximum; Specialist and non designated PCP: $40 Copay, applies to the $11,000 Out of Pocket Maximum	Not Covered

Prior Authorization is required for many services to be covered. For more information please refer to your benefit booklet.

PCY = Per Calendar Year. Balance billing may apply if a provider is not contracted with Premera Blue Cross. Members are responsible for amounts in excess of the allowable charge.

This is not a complete explanation of covered services, exclusions, limitations, reductions or the terms of the plan.This benefit highlight is not a contract and may change. Please see your benefit booklet or call Customer Service for full coverage information including a description of waiting periods, limitations, and exclusions.

Notice of availability and nondiscrimination 800-592-6804 | TTY: 711

Call for free language assistance services and appropriate auxiliary aids and services.
Llame para obtener servicios gratuitos de asistencia lingüística, y ayudas y servicios auxiliares apropiados.
呼吁提供免费的语言援助服务和适当的辅助设备及服务。
呼籲提供免費的語言援助服務和適當的輔助設備及服務。
Gọi cho các dịch vụ hỗ trợ ngôn ngữ miễn phí và các hỗ trợ và dịch vụ phụ trợ thích hợp.
무료 언어 지원 서비스와 적절한 보조 도구 및 서비스를 신청하십시오.
Звоните для получения бесплатных услуг по переводу и других вспомогательных средств и услуг.
Tumawag para sa mga libreng serbisyo ng tulong sa wika at angkop na mga karagdagang tulong at serbisyo.
Звертайтесь за безкоштовною мовною підтримкою та відповідними додатковими послугами.
សូមហៅទូរស័ព្ទទៅសេវាជំនួយភាសាដោយឥតគិតថ្លៃ ព្រមទាំងសេវាកម្ម និងជំនួយចាំបាច់ដែលសមរម្យផ្សេងៗ។
無料言語支援サービスと適切な補助器具及びサービスをお求めください。
ለነፃ የቋንቋ እርዳታ አገልግሎቶች እና ተገቢ ድጋፍ ሰጪ አጋዥ መሳሪያዎችን እና አገልግሎቶችን ለማግኘት በስልክ ቁጥር
Tajaajiloota deeggarsa afaan bilisaa fi gargaarsaa fi tajaajiloota barbaachisaa ta'an argachuuf bilbilaa.
ਮੁਫਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਅਤੇ ਉਚਿਤ ਸਹਾਇਕ ਚੀਜ਼ਾਂ ਅਤੇ ਸੇਵਾਵਾਂ ਵਾਸਤੇ ਕਾਲ ਕਰੋ।
Fordern Sie kostenlose Sprachunterstützungsdienste und geeignete Hilfsmittel und Dienstleistungen an.
ໂທເພື່ອຮັບການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ການບໍລິການ ແລະ ການຊ່ວຍເຫຼືອພິເສດທີ່ເໝາະສົມແບບບໍ່ເສຍຄ່າ.
Rele pou w jwenn sèvis asistans lengwistik gratis ak èd epi sèvis oksilyè ki apwopriye.
Appelez pour obtenir des services gratuits d'assistance linguistique et des aides et services auxiliaires appropriés.
Zadzwoń, aby uzyskać bezpłatną pomoc językową oraz odpowiednie wsparcie i usługi pomocnicze.
Ligue para serviços gratuitos de assistência linguística e auxiliares e serviços auxiliares adequados.
Chiama per i servizi di assistenza linguistica gratuiti e per gli ausili e i servizi ausiliari appropriati.
اتصل للحصول على خدمات المساعدة اللغوية المجانية والمساعدات والخدمات المناسبة.
برای خدمات کمک زبانی رایگان و کمک‌ها و خدمات امدادی مقتضی، تماس بگیرید.

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